PROTECTION OF THE ELDERLY

A STUDY OF ELDER ABUSE

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THE PROBLEM

There is a continuing increase in the size of the older population; it is estimated that with medical advances and a decreased birth rate persons sixty-five years of age and over could comprise approximately 12% of the population by the year 2000 (Steinmetz 1981). It is further estimated that by the end of this century, the population under 65 years of age will have increased 17% while those between 65 and 75 years will increase by 14%. The greatest increase, 53%, will occur among those 75 years of age and over. It is this group which is most vulnerable to physical, mental, and financial crises requiring family and societal care.

Along with the increase in the elderly population there has been an increase in attention given to concerns and needs of older people. In Manitoba, the Council on Aging and the Association of Gerontology have been concerned with clarifying needs and finding practical solutions to problems. One of these problems identifies that group of older people in Manitoba who are in need of help of some kind and for whom most communities have no appropriate services. More specifically, the Manitoba Association of Gerontology Subcommittee on Protection of the Elderly, and the Council on Aging have recognized the problem of elder abuse as one of growing urgency. "Abuse", as defined here, is any act of commission or ommission which results in harm to the elderly individual and is not restricted to physical harm but rather includes financial, psychological, and social abuse.

Estimates of the numbers of vulnerable and frail elderly in communities across the country are difficult to make with any accuracy. The U.S. Federal Council on Aging (1977) estimates that 9 to 20% of those 75 years of age and over may be frail (Regan 1978:251). Reports which describe the mistreatment of a frail or vulnerable older person have caused speculation about how widespread this problem might be. It is reported that in the U.S. each year one million elderly people may be the victims of moderate to severe abuse.[1] However, at present we have no reliable information concerning the magnitude of the problem in either the U.S. or Canadian population. But accounts of

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1. The Winnipeg Free Press, House of Representatives' Select Committee on Aging, Congressional Report, April 13, 1981.

elder abuse given by professionals who work with the elderly and brought to the attention of the Council on Aging, suggest that such abuse is not an isolated problem but rather a full-scale problem which exists with a frequency unreflected in open complaints and charges.

It is only relatively recently that the public has demanded protection for categories of individuals (for example, abused children and battered wives) considered to be economically dependent, politically weak, and lacking in adequate legal protection. Child and spouse abuse are now well-documented phenomena. More recent research has focused on the mistreatment of frail and vulnerable elderly persons. Generally, the research has focused on the vulnerability of older adults in terms of their victimization by strangers or mistreatment in institutional settings. However, only a small percentage (approximately 5%) of the elderly reside in institutions (Steinmetz 1981). According to the literature, neglect and abuse of older adults in domestic settings by their families and friends remains unclearly delineated due to a lack of data and a paucity of in-depth studies necessary for the development of a sound basis for describing the problem, identifying cases, and implementing programmatic remedies.

Physicians, social workers, and other practitioners who work with the elderly are frequently in a strategic position to identify abused elderly. O'Malley et al. (1979) in a mail survey of 1044 professionals, report that hospital social services directors, visiting nurses, private social services agencies, and home care corporations, most frequently indicated knowledge of cases of elder abuse. The lack of protective and preventive measures concerning elder abuse along with the absence of appropriate case management and long-term handling procedures for mistreatment cases among the elderly, places these practitioners in an untenable position. The vulnerable and frail elderly are often unable to provide their own protection and are, moreover, frequently reluctant or unwilling to bring charges against their abuser(s) particularly since the abuser is frequently a family member, close friend, or neighbour. Indeed, surveys of social service professionals and police statistics indicate that the greatest source of abuse of elderly persons is the family (Steinmetz 1981). According to Claude Pepper, chairman of the House of Representatives'

Select Committee on Aging in the U.S.,[2] the son of the victim is the most likely abuser, followed by the daughter; third in line is the spouse of the victim. This is substantiated by other recent research findings of increasing evidence of neglect and abuse of elderly persons by children, spouses, and other family members (Hickey & Douglass 1981b; Lau & Kosberg 1979; Steinmetz 1978, 1981). A double-bind situation exists which entraps many elderly persons when the individual recognizes a dependency on the abuser for provision of financial and other resources necessary for the elderly person's survival. Thus, abused elderly persons may elect to remain silent due to a lack of alternative shelter or fear of abandonment, the unavailability of supportive services, fear of the unknown, fear of reprisal, and a desire to avoid the shame, embarrassment, and stigma often involved. Given this reluctance to report abuse, combined with the legal and moral implications for caregivers and the defenseless position of the victim, determining the incidence and prevalence of mistreatment cases will continue to be difficult.

A common trait of vulnerable elderly persons is a degree of impairment which makes independent living a high-risk activity. When mental or physical impairment interferes with their judgement and their ability to manage their affairs adequately, they are at risk in the community. Without supportive services, remaining in the community, for many, is not possible. Some are forgetful about paying bills, resulting in the disconnection of necessary utilities and possible harmful consequences. These people require assistance with recurring events such as cashing cheques, payment of rent, utilities, and other expenses. Others become confused and depressed, failing to eat properly and may require social, medical, and home care supportive services. Others may become victims of mistreatment which may take the form of benign neglect such as the excessive administering by the caregiver of medication or alcohol in order to make the individual more manageable (Steinmetz 1978:54). Still others become victims of what has been referred to in the literature as "granny bashing" or "gramslamming". This abuse is lacking any benign intent and is, unfortunately, a growing phenomenon.

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2. The Winnipeg Free Press, op.cit.

Research of Hickey and Douglass (1981a) involving practitioners in a variety of professions, (N=228), providing services to elderly persons reports widespread mistreatment of older adults by their families. Neglect and abuse of elderly persons was familiar to most professionals interviewed and 60% of the respondents dealt with such cases on a weekly basis. Hickey and Douglass used two dimensions, passive and active, as measures of neglect. Verbal/emotional and physical dimensions were used as measures of abuse. Only 38% of respondents in the study reported no experience with physical abuse, and a much smaller number had no experience with neglect and verbal/emotional abuse. Passive neglect was considered to occur most often, followed by verbal/emotional abuse, active neglect, and physical abuse.

Hickey and Douglass report that 93% of the abuse cases studied revealed a family member as the perpetrator. Approximately 22% of the cases involved "passive" forms of abuse and included instances where the elderly individual's personal hygiene was ignored to the extent that large or infected bedsores had developed. Also included were instances of dependent older people whose food and necessary medications were withheld by family members for extended periods of time. In these instances of abuse the individuals were often described as severely malnourished and virtually immobile, yet receiving no assistance from family members residing in the same home. Approximately 32% of the cases involved instances of an older person falling or in some manner injuring themselves as a result of inadequate attention or avoidance of their needs for assistance. Approximately 19% of the cases revealed instances of financial abuse which included the taking of the elderly person's pension or social security cheques, the use of the funds to make purchases for other family members, and the charging of exhorbitant fees for routine assistance. Approximately 26% of the cases reported involved physical abuse by children and spouses. Such cases included direct physical assaults as well as more subtle forms of physical abuse such as rough handling of physically incapacitated elderly persons thereby increasing their pain or discomfort.

Findings from a survey (N=404) conducted by Lau and Kosberg (1979), indicate that abuse was inflicted by family members against nearly one in every ten elderly persons. This included beatings, extreme neglect, verbal

assaults, threats, theft, misuse of funds, forcing the elderly family member out of the home, and questionnable institutionalization. Physical abuse was reported in 78% of the cases, psychological abuse 51%, material abuse 31%, and violation of rights 18%. The existence of a mistreatment problem is further substantiated by findings of a survey of professionals (N=332) in which 55% of the respondents reported incidences of elder abuse during an eighteen month period (Steinmetz 1981):7). And in a report to the U.S. Administration on Aging in 1979 it is noted that 17% of professionals who participated in a mail survey reported incidences of physical abuse of an elderly person, and 44% reported incidences of psychological abuse. Unlike the findings of Lau and Kosberg, that the greatest percentage of abuse is physical, studies conducted in Connecticut, Maryland, Massachusetts, Michigan, Ohio, and Colorade all suggest that psychological abuse is more prevalent than physical assaults (Newsweek 1980:106).

Steuer and Austin (1980) undertook an analysis of twelve cases of elder abuse, identified mainly through requests by home health care nursing services for social worker intervention, and in fewer instances after hospitalization of the older person for medical problems. In nine of the twelve cases of family abuse, the elderly victims were frail women between the ages of 73 and 86, with physical and/or mental disabilities which made them dependent upon the caregiver for nutrition, medication, cleanliness, ambulation, and in extreme cases, bed care. Accordingly, exploratory research on elder abuse carried out at the Chronic Illness Centre in Cleveland, Ohio (Lau & Kosberg 1979) found that during a twelve month period (ending May 1978), of the 39 persons identified as cases of abuse (representing 9.6% of the agency's elderly clients), 30 were women with the majority being widows. In accord with Steuer and Austin's findings, over 75% of these women were frail and had at least one major physical or mental impairment. Case studies by Rathbone-McCuan (1980) indicate that abused elderly persons are generally female, 65 years of age and over, and functionally dependent because of inadequate resources or physical limitations. And O'Malley et al (1979), in a mail survey (N=1044 professionals) on elder abuse, report that victims are

likely to be women, 75 years of age and over. In 75% of the cases of elder abuse encountered by the professionals surveyed, the victims had mental or physical disabilities which prevented them from independently meeting daily needs.

As suggested by Bell et al (1981), the demographic weight of females in the elderly population must be considered. The proportion of elderly females involved in abuse cases may be somewhat congruent with their proportion in the aging population.

In the cases studied by Steuer and Austin, caregivers included spouses, children, siblings, or other relatives. In the majority of cases the caregiver was a daughter. In the abuse cases discussed by Lau and Kosberg, the majority of the elderly persons lived with a spouse, a daughter, or another relative, with over 68% of these being another relative. And O'Malley et al (1979) report that in 75% of cases, the elderly victim lived with the abuser, and in 84% of these, the abusing person was a relative. They do not, however, specify the exact relation of the abusing person to the abused.

Steuer and Austin report instances of physical neglect and abuse, and verbal/psychological abuse. Physical abuse in the form of beating or roughing up was quite rare. Instances of physical abuse were more often found to take the form of misuse of medication (i.e. over-sedation or the withholding of prescribed drugs). Physical abuse also included instances where the elderly person did not receive food regularly or was given a harmful diet, and where the elderly person was physically restrained or imprisoned in a room.

Steuer and Austin report that physical neglect was the most common form of abuse. Leaving non-ambulatory elderly persons unattended for extended periods of time was common and often resulted in ulcers and infections. According to the authors, verbal/psychological abuse occurred on a more subtle level but was not necessarily less damaging than physical abuse. Instances of derogation, infantilization*, threats of institutionalization, abandonment, and homicide were encountered. In one-third of abuse cases studied by Steuer

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* Infantilization results when adult children strip parents of independence and responsibility for self-maintenance. Rather than differentiating the areas that the elderly can manage themselves, the adult children allow no mutual participation in the decision-making process (Miller 1981:43).

and Austin, money appeared to be the important factor in the caregiver's desire to keep the older family member with them, even if only to appropriate their social insurance cheques.

It is clear that some elderly people in the care of relatives or friends are seriously mistreated in their own homes or the homes of their children and other family members. Although the range of types of mistreatment extends from a benign lack of attention to serious physical abuse, it is difficult to devise any scale of severity since, among the frail and vulnerable elderly, some forms of emotional abuse (Hickey & Douglass 1981) or verbal/psychological abuse (Steuer & Austin 1980) can be equally as damaging as physical abuse, although the consequences may not be as readily apparant.

Implications drawn from the above discussion would appear to be in the direction of the continuing need for formal systems of care and the development of protective services. According to Hickey & Douglass (1981a:506), many practitioners presently believe that the real domain of protective services for older adults is with the homeless and destitute, those without family or friends. However, the above research suggests that a greater degree of involvement of protective services in domestic situations and a greater concern with dependent older adults in intact households, is warranted.

A survey conducted by Shanas (1979) found indications that families are increasingly providing long-term care for the elderly rather than placing them in institutions. Indeed, there appears to be a growing trend toward the rejection of nursing homes, and long-term care facilities in general, for the aged, and an increasing number of families are apparently becoming involved in the care of their elderly members. Research suggests that the more serious forms of abuse are likely to occur in domestic settings in which the caregivers are ill-equipped or reluctant to care for dependent adults (Hickey & Douglass 1981; Regan 1978; Steinmetz 1978). If these caregivers believe that any domestic care is better than institutional alternatives, together with the possibility that inflation will cause an increasing number of older adults to reside with families, then greater numbers of vulnerable elderly persons

may be at risk of abuse. Without an increase in support systems and protective services such mistreatment may become more prevalent.

Etiology:

The increasing evidence and growing public awareness of neglect and abuse of elderly persons have caused speculation about why it happens. A review of the literature indicates that no single explanation for mistreatment of elderly persons predominates. A recent study (Hickey & Douglass 1981b) based on case experiences of professionals who deal with elderly persons on a regular basis reports that most respondents attributed multiple causes to problems of elder abuse or at least viewed various explanations as overlapping. Widely discussed explanations for mistreatment of elderly persons include the following:

- Pathological behaviour and the vulnerability or dependency of the victim.
- A developmental, or life-cycle approach, based on social learning and modeling in which the pattern of violence continues from generation to generation through established behaviour patterns.
- An environmental approach: the situational explanation of mistreatment based on irrational reactions to life-crises and mistreatment as a result of negative environmental conditions of a more long-term nature.

A pathological framework explains mistreatment in terms of personal or pathological problems inherent in the abuser. Family members become vulnerable to neglect or abuse because of their proximity to and/or dependency on others who have such problems. This framework emphasizes the psychiatric problems of the abuser. However, according to Brennan (1977:33), a psychiatrist in England, psychiatric illness is rarely a cause of elder abuse. He reports that psychiatrists find the greater proportion of these cases to present no genuine pathology.

A developmental approach views mistreatment behaviour as a recurring phenomenon within the family and suggests that children of dysfunctional parents are themselves unlikely to develop integrated relationships. According to this explanation, mistreatment is potentially cyclic in nature and related to the family's history of violent patterns over several generations. Although a lack of concensus regarding the etiology of family violence is evident in the literature, research is consistent in revealing that abusive adults were themselves more likely than not to have been the victims of such behaviour as children. According to such research, patterns of interaction are established and childrens' negative behaviours learned from being abused are likely to continue. Thus, a developmental or life-cycle approach views abuse in interactional terms with the likelihood of abused children continuing the negative behaviour later in life when dependency roles are reversed.

An environmental approach conceives of mistreatment from a social structural perspective and hence posits explanations based on long-term environmental conditions and situational conflicts are crises. Under this framework, earlier development is less important than present situations and social conditions. However, this approach appears unable to account for the fact the individuals experiencing similar situational and environmental conflicts and crises behave differently. This suggests that environmental factors, although important, are insufficient predictors of neglect and abuse. Indeed, each of the above mentioned explanations, when taken alone, is unable to adequately account for all family violence.

A recent study (Steuer & Austin 1980) posits caregiver alcoholism as one possible cause of elder abuse. In 25% of the cases studied the caregiver was an alcoholic. In clinical practice, Brennan (1977:32) reports that in several cases caregiver alcoholism was directly associated with elder abuse. And case studies undertaken by Rathbone-McCuan (1980) revealed abusive behaviour toward elderly family members to be associated with the caregiver's consumption of intoxicants. Further, O'Malley et al (1979) report that in 75% of the cases of elder abuse encountered, the abuser was experiencing some form of stress, one such stress being that of alcoholism.

Research findings of Hickey & Douglass (1981b) and Steinmetz (1978) suggest that the sudden and unwanted dependency of a parent and the autonomy and private nature of the family provide an environment for mistreatment and are key factors in understanding neglect and abuse. Dependent individuals, relying on others for basic survival needs, are in a vulnerable position. They are presumed protected by virtue of the caring that it is assumed the family provides. However, childhood and late-life dependency differ in the degree to which they are perceived as permissible. While the costs (emotional and economical) of caring for one's children are a recognized burden, the responsibility for the care of elderly family members over a prolonged period has not been as widely acknowledged and may become a burden carried with great ambivalence. Hence, older family members may become vulnerable to abusive treatment triggered by the dependency relationship when their dependencies are viewed as unacceptable.

The dependent elderly person can be a source of emotional, physical, and financial stress to the adult children who may be unprepared or unable to assume these responsibilities. Some families may become overwhelmed by the constant supervision they may be called upon to provide and the lack of supportive services to assist in the care of the aged person. According to a U.S. congressional inquiry*, this lack of services combined with inflation and rising unemployment, place the caregivers in an emotional pressure cooker.

Based on their research findings, Hickey & Douglass (1981a) conclude that the most critical factors associated with abuse are the caregivers' lack of ability or disinterest in responding to the needs of vulnerable family members, and their willingness to accept the dependency relationship of an older adult. Other research suggests that middle-aged children may experience feelings of deprivation or depression due to the responsibility of caring for an older family member at a time when responsibility for their children has nearly ended (Anderson 1981:79). Anderson reports research findings that the health of the elderly person and caregiver attitudes toward aging are significant correlates of the quality of the relationship. Poor health of the older

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* Geriatric Nursing, "Elder Abuse in the Home Found Widespread by Congressional Inquiry", Sept/Oct., 1980.

adult increases dependency and can lead to an increase in feelings of resentment by the caregiver. Additionally, research suggests that many family members caring for dependent older adults are themselves likely to be elderly. Anderson (1981:78) reports on a study in which 75% of the subjects who were principal caregivers for elderly people were themselves over 50 years of age and nearly one-fifth were over 70 years of age. Research conducted by Steinmetz (1981) reveals that 57% of the caregivers were elderly or nearing this stage and in addition to retirement and fixed incomes, and increased health problems, were bearing the responsibility for a still older dependent family member. Steinmetz's research identifies this additional burden as a breaking point with a potential for abuse. Research of Lau & Kosberg (1979) adds further evidence to substantiate the finding that the increasing strain placed on caregivers who are themselves elderly may provide a situation conducive to potential abuse.

Protective Services and Legal Mechanisms:

"Protective Services" is traditionally defined as a system of preventive, supportive, and surrogate services for adults living in the community to enable them to maintain independent living and avoid abuse and exploitation (Regan 1978:251). Protective services programs are generally characterized by two features: the coordinated delivery of services to adults at risk, and the authority to provide substitute decision-making. The service component may consist of various health, housing, and social services (for example, provision of homemakers, meals, and visitors; assistance with home maintenance, etc.). These and other services are generally coordinated by caseworkers who are responsible for the assessment of needs and the coordination of agents or agencies for the delivery of service.

The authority to intervene directly involves the legal system and, as a general rule, requires not merely a presumption of harm to the client, and benefit by intervention, but also evidence of an inability to protect oneself or a diminished capacity to make decisions (Ho 1981:8). This aspect of protective services involves an intrusive element which includes such legal mechanisms as Power of Attorney, Committeeship, and Order of Supervision.

A Power of Attorney is a legal document authorizing another person to act on one's behalf as an agent. The person creating the Power of Attorney must, at that time, have the capacity for understanding what he/she is signing. The scope of a Power of Attorney is generally restricted to certain specified financial transactions and is revocable by the client, although a "durable" nature may be specified in order that it remain in effect in the event that the signee becomes mentally incapacitated (Ho 1981:9). A major problem with a Power of Attorney document is that the person who is given the power does not legally have to account to anyone except the donor (Katz & Larsen 1975:11). Recommendations of the Manitoba Law Reform Commission, in its report on Special, Enduring Powers of Attorney (1974), included that the person receiving the power be required, in certain circumstances, to account to the Public Trustee. There has been concern expressed that a person who is given this power by an older person may not report to that person who, for one reason or another, is not asking any questions. In such cases, it is possible that finances may be misused without the knowledge of the person who granted the Power of Attorney. Interestingly, the Task Force on Domestic Violence recommended to the Ohio legislature in January 1978, that all Power of Attorney documents consented to by elderly persons should be examined by the courts to assure that it is given knowingly, intentionally, and without duress (Littleton 1978:25).

A committeeship involves the appointment by the Court of Queen's Bench of a person(s) to manage another person's estate without a declaration of mental disorder (the designation is "mental infirmity" and "incapability"). The appointed person(s) is referred to as a "committee". The court's practice is to require two medical certificates, an inventory of the assets of the estate filed within six months by the committee, and an accounting filed every two years thereafter. A committeeship is usually granted to family members. Since a committee is not required to provide the mentally infirm person with any information regarding the estate (Katz & Larsen 1975), the potential for abuse by relatives exists. There is no way under the present law that an estate can be protected without at the same time declaring an individual mentally disordered and transferring committeeship to the Public Trustee under

an Order of Supervision. Manitoba's Mental Health Act does not, according to Katz and Larsen (1975), give adequate attention to the committeeship of estates of persons who are not mentally disordered, but who lack the specific abilities required to conduct financial affairs. With the exception of financial matters, such persons should be allowed to retain control over other daily living matters. Currently, they have to be declared mentally disordered for the transfer of committeeship to the Trustee when the conduct of the previous committee becomes questionable.

Legal intervention under an Order of Supervision invests the Office of the Public Trustee with the power and responsibility to assume control over the person and estate of another individual adjudicated by the courts to be mentally disordered. Hence, to justify the enactment of Orders of Supervision a court must find that a person is incompetent. The currently proper legal term in Manitoba is "mentally disordered"; since 1965 the term "mentally incompetent" has not been used in Manitoba's mental health laws. The Mental Health Act defines "mental disorder" as "mental illness, mental retardation, psychoneurosis, psychopathic disorder, addiction, or any disability of mind caused by disease, senility, or otherwise".

Since an Order of Supervision is a legal device with potential harmful consequences, there is merited concern regarding its use to deal with an increasing population of frail elderly. Much of this concern relates to conflicts between attempts to provide protection to selected persons and the individuals' basic civil rights, autonomy, and freedom from stigma. This has led to further concern regarding the use of this extreme form of intervention in place of less restrictive forms of social intervention. However, in the absence of any other form of protection for abused elderly, the Order of Supervision is often recommended. Consequently, the person is declared mentally disordered, and loses civil rights and liberties as well as control over property and finances. This is not to say that such legal mechanisms are not, in some cases, appropriate. However, although it may often be the only practical and feasible alternative available, it is beginning to be viewed negatively and punitively, as involving the placing of restrictions on individual

rights and privileges. There appears to be a growing resistance to declarations of mental disorders in order to provide protection to individuals who are not totally incapable of caring for themselves or managing their affairs.

According to a description of the American situation (Regan 1978:251), there is often little attention given to the functional abilities of the individual, and the inability to care for oneself or property, resulting from frailty or social incompetence is often equated with mental incompetence, senility, mental illness, or pathological behaviour. From a review of available literature, it appears to be the "all-or-nothing" nature of many legal mechanisms that often make them inappropriate and repressive means for assisting elderly persons who are capable of making decisions, but who, for various reasons, cannot carry out their wishes unassisted. According to Cohen (1978:37), many elderly persons merely suffer from some memory loss and unfamiliarity with legal processes and do not lose their judgement concerning personal goals relative to their estates. Others may be socially incompetent but retain the capacity to handle basic needs and therefore do not require the many restrictions entailed in Orders of Supervision. Such persons may require assistance of a more flexible nature; assistance tailored to their individual capacities and designed to enable them to retain control over other decisions which they are capable of making without such assistance.

The Order of Supervision has also received criticism due to its lack of provision for protection in all spheres of life including personal supervision and physical protection. The primary purpose of the Order is to protect an estate. Its main advantage, therefore, rests essentially on protection of an individual's financial assets through transfer of responsibility for such to the Public Trustee.

The above discussion of legal mechanisms highlight the problem of protection of property versus protection of personal welfare. It would appear that there is a need for protective services which distinguish between financial management and personal supervision in order to monitor or control protective problems in all spheres. Furthermore, when the law is currently

used as a means of extending help to older persons, issues of invasion of privacy versus preservation of rights become involved. Clearly there is a need for the development of services that will adequately handle protective problems while preserving personal autonomy.

A review of available literature further suggests a significant number of procedural deficiencies in declarations of mental disorder (Order of Supervision) and mental infirmity (Committeeship). These deficiencies appear to be associated mainly with the court procedure, vagueness of criteria for determining mental infirmity or disorder, and weakness of the review function. According to some critics, when an Order of Supervision or Committeeship is petitioned, the application is granted almost invariably (which appears to lend support to a "rubber stamping" tendency of the courts). In most instances, the presence of the elderly person at such hearings is either not required and/or not enforced. In the U.S., California is the only state that insists on the personal attendance of the person being adjudicated or a physician's affidavit certifying the individual's inability to appear (Bell et al 1981:200). California utilizes the mechanism of a Court Investigator who is required to make a personal visit to the elderly person, alert him of the steps being taken, inform him of his rights, report general assessments to the court, and visit those adjudicated at periodic intervals later.

According to discussions of the American situation, determinations of incompetency, as they are called in the U.S., are often based on physical incapacity rather than the ability to make rational decisions regarding person or property (Bell et al 1981; Regan 1978). Currently, in Canada, there appears to be no professional screening group charged with the responsibility of assessing the physical, mental, and social needs of persons subject to Orders of Supervision or Committeeship. Such a group would be invaluable in determining types of intervention deemed necessary and subsequently recommending the least restrictive or invasive course of action consistent with the individual's needs.

It is not the purpose of this study to argue for a termination of assistance rendered through Orders of Supervision or Committeeship, but rather for the development of less restrictive or invasive alternatives and a strengthening of adult protective services. Since traditional "incompetency" laws appear to be inappropriate and repressive in some cases, alternative solutions must be developed which will enable frail and vulnerable elderly persons to remain in the community at less risk. Frail-elderly persons who are vulnerable but not mentally disordered and who have neither friends nor family to properly assist them, do not currently have access to protection. It is for this group and those who suffer abuse at the hands of others, (albeit relatives), that the law must make some accommodation.

The provision of required services can range from information dissemination, consultation, referral, homemakers, housekeepers, escort services, shared homes, out-patient treatment and day or night treatment in a hospital, to consultation teams composed of representatives from various professions to determine the need for intervention. This multidisciplinary approach is necessary for the successful identification and management of situations of abuse and involves at least three major systems -- the medical system, the legal system, and the social service system.

Preventive Measures:

A result of the general unawareness of the phenomenon of elder abuse among both the public and professionals, is a lack of protection and assistance to caregivers and to elderly victims. Furthermore, because the problem has gone largely unrecognized, no efforts have been made to prevent this form of abuse. Strategies should be developed which can deal with the problem of elder abuse before rather than after-the- fact. The early detection of cases of abuse through a program of early case finding would identify both abused elderly and high risk situations. "Detection" has been defined as "an ability to identify the individuals or groups who are experiencing difficulty or who are in danger of becoming vulnerable and to detect and identify conditions in

the environment that are contributing to the problem or raising the level of risk." (Thorman 1981:68). Standardized procedures for identifying and handling cases of elder abuse are necessary. The guidelines formulated at Seven Oaks General Hospital are an example of an effective detection approach. These include high social risk factors, to assist in the identification of circumstances which may indicate abuse or neglect. The Seven Oaks Guidelines and High Social Risk Factors are presented in Appendix B. The guidelines also serve the purpose of alerting staff at Seven Oaks to the need for measures or resources which will alleviate or reduce risk factors in the aged person's environment.

The potential for abuse can be determined through careful observation and asking a series of questions concerning the relationship between the caregiver and the older person, and their methods of dealing with stressful situations. In child abuse cases, the way the caregiver thinks others regard him as a caregiver has been identified as an important concern (Thorman 1980: 148) -- the caregivers are generally concerned about their ability to meet the needs of the dependent person and questions designed to tap feelings of anxiety or uncertainty may identify situations with a high potential for abuse. Such questions may reveal cases where the caregiver is overwhelmed by the responsibility of caring of a dependent older person. The literature on spouse abuse suggests that the victim is subject to certain psychological effects such as a loss of self-esteem, depression, fear, and a sense of hopelessness and helplessness. According to the literature on elder abuse, similar reactions may be present in the elderly. According to Anderson (1981:78), these reactions of elderly victims may take the form of denial, resignation, withdrawal, fear, depression, or mental confusion. The Seven Oaks Guidelines contain possible reactions and attitudes of the abused elderly person and of the abusing caregiver, and are presented in the Appendix.

Risk Reduction Strategies:

1. Central Registry: One approach to risk reduction is the establishment

and maintenance of a central registry of all reported information in cases of abuse. Mandatory reporting of abuse cases to a central registry could provide immunity from liability for anyone reporting a case in good faith. The reports should be followed by immediate investigation of cases. A registry would be useful in creating an awareness of the extent of the problem as well as for identifying any previous incidents of abuse recorded with respect to the same individual and alerting protective services programs so that an appropriate course of action can be taken. As well as providing protection against continuing abuse, a registry would, through the recording of types and incidences of abuse, provide the data necessary for research, program planning, and service improvement.

Seven Oaks has recognized the need for a registry of elder abuse and has implemented the first of its kind in Manitoba. Suspected cases of abuse encountered at the hospital are now being documented. Each report includes date, name, address, sex, and age, as well as information concerning the suspected type of abuse or potential risk situation (for example, a disabled elderly person living alone or with an infirm care provider). The name of the staff member reporting the suspected case is also recorded along with descriptions of any action taken. While the formation of a registry is a beginning and an important step in the direction of protection, it is of course not the total answer to the problem of abuse. It is merely a tool for the identification of abused elderly persons. In order to adequately handle cases of elder abuse the creation of avenues for protection and prevention is necessary and a full commitment to protection of elderly persons requires provision of a wide range of services and may call for large-scale action in legislation in order to provide effective programming.

2. Education: Education as a preventive measure would disseminate knowledge concerning aging and the needs and care requirements of the aged. Many caregivers may require information concerning practical problems such as budgeting, meal planning and nutrition. Additionally, informal group discussions could be useful methods of counselling families caring for elderly members, especially

those identified as being at risk, to become more patient and more understanding of the importance of sound information concerning elder care and the importance of their roles. Caregiver education and counselling could help the caregiver gain relief from feelings of frustration or anger brought on by the responsibility of caring for a dependent adult, and subsequently to deal with their feelings other than through physical force or other forms of mistreatment.

Education of caregivers in high risk situations could be carried out by carefully selected and well-trained volunteers who would serve as adjuncts to a social agency's professional staff. Also, volunteers, as well as providing information and referral services, could visit with families and help caregivers with day-to-day problems. The development of programs to recruit and train volunteers could be beneficial to all in that the numbers of abusive and high risk situations that could be reached would be expanded. Such programs would also allow professionals a greater amount of time for group and individual counselling.

3. Crisis Intervention: The crisis intervention model is based on the premise that "any hazardous event upsets the emotional balance of individuals and families and creates serious problems of readjustment". (Thorman 1981:56). Studies of abusing families suggest that in many cases, a crisis in the family's life situation has precipitated abuse. A caregiver's ability to cope with crisis depends not only on inner resources but also on the community resources available to help resolve the situation and aid in readjustment. Referral of caregivers and older dependent adults facing difficult situations to these resources could be crucial to the prevention of abuse.

The training of law enforcement officers in early and effective intervention techniques involving referral to helping agencies has proven to be beneficial. An interesting example is provided by a family intervention training experiment undertaken in West Harlem. A month-long training program was provided to officers, and included lectures, workshops, field trips, and role playing (Thorman 1981:157). To determine the effectiveness of the training a comparison of the experimental unit was made with a regular precinct unit. It was found that the precinct unit made no referrals to social and mental health agencies, while the experimental unit made referrals to twenty

such agencies in 55% of all cases of family violence encountered.

4. Advocacy: The risk reduction strategies discussed above call for the establishment of a wide range of social services that reach out to elderly persons at risk. These services could include homemaker and housekeeping services, day care facilities, financial aid for families caring for an older dependent adult, and workers to escort clients through the various agencies. Since the abused elderly can often not protect or speak for themselves, advocacy programs and services must also be developed. "Advocacy" is defined as the "ability to fight for the rights and dignity of people in need of help ... fighting for services on behalf of a single client or segments of society." (Thorman 1981:69). It has been suggested that advocate programs emanate from an organizational base employing volunteers backed by professional staff (Cohen 1978:38). These volunteers would play the role of "agents" and could, for example, develop fiduciary relationships with those older persons requiring assistance. This would involve the consent of the elderly individual that the agent act on his/her behalf. The agent would be under obligations similar to those imposed upon a trustee, i.e. "to act with the utmost good faith ... for the furtherance and advancement of the interests of one's principal." (Cohen 1978:38). Cohen further suggests that agents be volunteers rather than social workers since the ability of a social worker to act as an agent would be severely limited by the sheer size of the caseload with which the worker must already contend.

Advocates for the elderly could work for legislative reforms, public enlightenment and assistance, and the creation of new services such as shelters, legal, medical, housing, and counselling services, and the linkage of clients to the system of services that meet their needs. The public is largely uninformed about the extent and nature of elder abuse. A lack of awareness, and probably denial, accounts for some of the silence that has surrounded the issue. According to Star (1980:346), the lack of adequate services for victims and abusers corresponds, in part, to the lack of knowledge about the incidence of abuse. And since the establishment of a system of services needs a wide base of support, advocacy programs could also provide

public information through media coverage in order to promote an awareness of problems, and for example, the distribution of brochures which would help educate and sensitize the public to the nature of the problem as well as increase professional awareness. The education of professionals in the area of elder abuse (and their involvement in program planning) is essential to program support and to working for new legislation and policies. It is an emotionally charged subject, but only through public and professional awareness of the existence of the problem can help be offered to both victims and abusers.

Through advocacy programs the elderly would be more likely to receive the assistance required to help solve the problems confronting them. Such programs would also advocate for the caregivers. In both cases, this could range from, for example, those who have sought, and been denied, financial assistance and those who would benefit by being accompanied through the legal procedures involved in applications for assistance, to enlisting the assistance of a legal aid representative to advocate for a person in regard to eviction.

Advocacy programs could take a multi-disciplinary approach similar to child protection programs. Members of various professions would participate so that the base of knowledge and experience for the making of decisions and recommendations would be expanded. Primary team members might include social workers to assume the responsibility for evaluating the safety of the home and treatment strategies; physicians and psychiatrists to act as diagnostic experts in cases of abuse; coordinators to coordinate the efforts of the different agencies involved; attorneys for clarification of legal matters; law enforcement officers, since they may become directly involved initially; and public health nurses to assume responsibility for delivery of health care services. This multi-disciplinary team would periodically review cases to determine plans of action, and to revise plans in light of new information and new needs, and formulate preliminary and long-term recommendations.

Summary:

In summary, the elderly are appropriate for study of abuse for many

reasons, including the following. Due to better living conditions and medical advances, more people now live longer. The demands on medical and social service agencies are increasing as the age group seventy-five years and over, who constitute a greater percentage of frail elderly, increases. This age group is increasing in numbers as well as in proportion to the aging population. There is increasing concern for the plight of the frail elderly -- those non-institutionalized but at-risk older adults who have difficulty in coping without the support and assistance of another. And in the absence of other less restrictive protective avenues, many frail elderly, must be found "incompetent" by the courts.

Mistreatment of the elderly, in the forms of neglect and abuse, appears to be no small problem; the research reviewed above suggests that such cases are not the rare exceptions. Such research warrants concern regarding the significance of the problem for those older individuals and families affected.

In the absence of a capacity or desire on the part of others in the aged person's environment to intervene, enlist the necessary authority, or in some manner exercise the means to prevent abuse, neglect, exploitation, or other consequences, resulting from the elderly person's vulnerability, the public sector becomes involved in care and protection. A main objective of this study is to explore the nature of the situation, to identify areas of unmet need and/or gaps in service, and to offer practical solutions which may be of assistance to those individuals and agencies committed to the protection and the safeguarding of rights of abused elderly persons. It is hoped that this study will stimulate policy-making which will provide for more comprehensive systems of care for elderly persons at risk of abuse or neglect.

With this in mind, the following section will present the methodology of the present study, beginning with descriptions of the data. Following this, the results will be reported. Finally, limitations of the study will be discussed, conclusions formulated, and implications and recommendations set forth.

METHODOLOGY

Due to the sensitive nature of the problem, it was understood that collecting accurate and complete data would be difficult. Therefore, it was not the objective of this study to undertake a definitive scientific survey of the extent and nature of the problem of elder abuse.

There seems to be no question that there is a population of unspecified size among the frail elderly who are vulnerable to neglect and abuse and who are in need of protective services. Practitioners working with the elderly on a regular basis constitute an important resource for information concerning the problem. Such individuals would presumably have first hand knowledge of mistreatment cases. Accordingly, this study utilized, as its main source of data, interview material obtained through contacts with practitioners in various professions intimately concerned with the subject, the diversity of which should yield observations and experiences by those dealing with older adults in different contexts. Additionally, document and case record analysis was undertaken whenever possible.

A semi-structured, open-ended interview format was employed and attempted to elicit information, based on the practitioners' experiences, regarding neglect and abuse of elderly persons. As well as detailed descriptive accounts of elder abuse cases, the interview content focused on methods of identification of such cases and procedures with which they were handled. Respondents were also asked opinion items which included such issues as mandatory reporting, indicators of high risk situations, and attitudes concerning issues of protocol, legislation, and advisory committees.*

Because there is no way of knowing the numbers of abused elderly persons in the population, the decision was made to utilize a "snowball" technique (Biernacki & Waldorf 1981) in interviewing. Thus, included in the interview were questions designed to provide "leads". The snowball technique facilitates

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* Interview items are presented in Appendix A, page 53

research on sensitive issues since one can begin with a limited number of contacts and branch out to a wider population.

Interviews, (N=105), were conducted within all regions of the province -- Winnipeg, Central, Norman, Interlake, Parklands, Westman, and Eastman -- thereby representing both urban and rural areas and populations ethnically and socioeconomically diverse. Respondent types included public health nurses, social workers, psychiatric nurses, Victorian Order of Nurses, RN's in home care programs as well as hospital settings, police officers, doctors, lawyers, and clergy members.

It is recognized that the results may not be representative of abused elderly persons in the total population, since numerous selective factors may operate to determine which of all abused elderly persons become identified. Since, of course, no attempt is made to generalize to the entire population, the non-random nature of the sample is not seen as problematic.

Operational Definitions:

In order to operationalize the concepts of financial, psychosocial, and physical abuse, the following definitions were formualted.

Physical abuse is defined as situations involving physical assault, rough handling causing physical injuries or discomfort, injuries or gross neglect caused by others, avoidance of needs for assistance, and the withholding of physical necessities such as food, personal and hygienic care, or medical care.

Psychosocial abuse is defined as confinement, isolation, inadequate attention in terms of time, concern, and understanding of needs, and the removal from active participation in one's own life. This category further includes verbal/emotional abuse which, as defined by Hickey & Douglass (1981), relates to humiliation, intimidation, derogation, infantilization, or any treatment diminishing identity, dignity or self-worth.

Financial abuse is defined as situations relating to monetary matters and involves the withholding of finances, trickery, fraud, theft, misappropriated or misused funds or property. This category includes instances of withholding of the means for daily living necessities.

It is recognized that considerable overlap may exist. For example, the withholding of the means for daily living necessities may be considered financial abuse, while also having potential physical and psychosocial consequences. Further, the confinement of older persons in separate rooms or bedrooms may be considered as both physical and psychosocial abuse. To handle instances of overlap, where more than one type of mistreatment was identified in the same case, these were each recorded. While notation was made under each category of abuse, an over-count was avoided through identification of these instances as one case.

RESULTS:

402 cases of elder abuse were described. When more than one category of abuse was identified in any one case these were each recorded and resulted in findings of 540 instances of elder abuse. Breakdown into the three categories of abuse is as follows: financial abuse = 217 instances or 40.3%, psychosocial abuse = 202 instances or 37.5%, physical abuse = 121 instances or 22.5%.

105 interviews were conducted with professionals dealing with cases of elder abuse. The following table presents a breakdown of occupational categories of respondents.

TABLE I

Percent of Respondents by Occupational Categories

N=105

Occupational Category	Percent
Public Health Nurse	40%
Social Worker	28
Psychiatric Nurse	8
Victorian Order of Nurses	7
Administrator	5
RN - Home Care Program	5
Police Officer	3
RN - Hospital Setting	2
Physician	2
Lawyer	1
Clergy	1

Of all reported instances of abuse, the percentage encountered by respondent type is presented in Table II as well as the percentage of cases encountered within each category of abuse by respondent type.

TABLE II

Percent of Total Abuse Instances and Specific Abuse Category Instances by Respondent Occupational Category

Category of Abuse / Respondent Category	Financial	Psycho-social	Physical	Financial	Psycho-social	Physical
	N=540			N=217	N=202	N=121
Public Health Nurse	15.6%	15.6%	6.3%	38.7%	41.6%	28.1%
Social Worker	12.0	11.0	8.0	30.0	29.2	35.5
Psychiatric Nurse	5.9	4.1	2.4	14.7	10.9	10.7
Administrator	1.5	1.7	2.0	3.7	4.5	9.1
Victorian Order of Nurses	.6	1.5	1.3	1.4	4.0	5.8
RN - Home Care Program	2.0	1.7	.6	5.1	4.5	2.5
RN - Hospital Setting	.2	.6	.6	.5	1.5	2.5
Police Officer	.6	.4	.6	1.4	1.0	2.5
Physician	.4	.6	.6	.9	1.5	2.5
Lawyer	1.1			2.8		
Clergy	.4	.6	.2	.9	1.5	.8

This study finds financial abuse to be the most frequent encountered type of abuse of elderly persons, followed by psychosocial and physical. As presented in Table II, the data suggest that of all reported instances of abuse, the greatest percent of financial and psychosocial abuse cases were encountered by public health nurses while social workers encountered the greatest percent of physical abuse cases.

Tables III, IV and V present the dimensions within each category of abuse and the relative frequency with which they were encountered.

TABLE III

Percent of Instances of Financial Abuse by Dimensions of Financial Abuse

Dimension	Percent
Cashing pension/social insurance cheques and withholding the means for daily living necessities	50.4%
Trickery, fraud, misappropriated/misused property	10.3
Theft of funds and/or possessions	9.8
Trickery, fraud, missappropriated/misused funds	8.9
Grossly overcharged for residence	6.7
Taking pension/social insurance cheques or other funds through threats or force	5.8
Grossly overcharged for small services and/or items	4.9
Sold house and/or furnishings without permission and withheld funds from sale	3.1

TABLE IV

Percent of Instances of Psychosocial Abuse by Dimensions of Psychosocial Abuse

Dimension	Percent
Verbal/emotional: derogation, humiliation, intimidation, infantilization, or any treatment diminishing identity, dignity, or self-worth	38.6%
Inadequate attention in terms of time, concern, and understanding of needs; left unattended for extended periods of time	17.5
Isolation	13.9
Confinement	11.2
Removal from active participation in one's own life	7.2
Threats of harm or violence	6.8
Threats of withholding assistance, abandonment or institutionalization	4.8

TABLE V

Percent of Instances of Physical Abuse by Dimensions of Physical Abuse

Dimension	Percent
Physical assault	35.1%
Withholding food	11.7
Rough handling, pushing, or shoving resulting in injuries or discomfort	11.0
Gross neglect resulting from avoidance of needs for assistance with daily living (eg. personal and hygienic care)	11.0
Withholding medication and/or medical attention	7.8
Injuries resulting from avoidance of needs for assistance	5.2
Deliberate over-medication (pills or alcohol)	5.2
Sexual assault	4.5
Homicide	3.9
Physically restrained (tied, gagged)	2.6
Injuries resulting from deliberate hazardous situations	1.9

Inspection of the above tables indicates that of all dimensions within the financial abuse category, the taking and withholding of elderly persons' pension or social insurance cheques was the most frequently encountered -- indeed, 50.4% of all reported cases of financial abuse fall within this dimension. The use of threats or force by caregivers in order to appropriate the elderly persons' funds accounted for 5.8% of financial abuse cases. 10.3% of financial abuse cases involved trickery, fraud, misappropriated or misused property of an elderly person while 3.1% of cases specifically involved the sale of the elderly person's home and/or furnishings without permission. In these instances, the funds from the sale were withheld from the elderly person. While outright theft of funds and/or possessions accounted for 9.8% of financial abuse cases, 8.9% of cases involved misappropriated or misused funds and included the use of trickery or fraud. In 6.7% of all financial abuse cases the elderly person was grossly overcharged for residence, while 4.9% of cases involved elderly persons being grossly overcharged for small services and/or items.

The greatest percentage, 38.6%, of all encountered forms of psychosocial abuse fall within the verbal/emotional dimension which relates to derogation, humiliation, intimidation, infantilization, and any treatment diminishing identity, dignity, and self-worth. Psychosocial abuse in terms of threats of harm or violence accounted for 6.8% of cases while threats of withholding assistance, abandonment, or institutionalization accounted for 4.8% of cases. 17.5% of all cases of psychosocial abuse fell within the dimension of inadequate attention in terms of time, concern, and understanding of needs, and included leaving elderly persons unattended for extended periods of time. The removal from active participation in one's own life accounted for 7.2% of all psychosocial abuse cases. Isolation and confinement of elderly persons accounted for 13.9% and 11.2% of cases, respectively.

As shown in Table V., physical assault was the most frequently encountered dimension (35.1%) within the physical abuse category. 3.9% of all cases of physical abuse resulted in the death of the elderly person. Sexual assault accounted for 4.5% of physical abuse cases. 2.6% of cases fell within the dimension of physical restraint (i.e. tied and gagged), while 11% of all cases

involved rough handling, pushing, or shoving resulting in injuries or discomfort. Caregivers deliberately causing hazardous situations which resulted in injuries to elderly persons accounted for 1.9% of physical abuse cases. Injuries resulting from avoidance of needs for assistance accounted for 5.2% of cases, while gross neglect resulting from avoidance of needs for assistance with daily living (for example, personal and hygienic care) accounted for 11% of cases. 11.7% of cases fell within the dimension of withholding food while 7.8% involved withholding medication and/or medical attention and deliberate over-medication (pills or alcohol) accounted for 5.2% of cases.

This study finds 67.7% of identified abused elderly persons to be female while 32.2% are male. The data further suggest that the most frequently abused elderly person is a female aged 80-84 years, residing with a family member for 10 or more years. Characteristics of abused elders are presented in tables VI and VII.

TABLE VI

Percent of Abused Elders by Age and Sex

Age \ Sex	Female	Male	Total
60-64	8.0%	2.0%	10.0%
65-69	9.7	5.5	15.2
70-74	8.7	6.2	14.9
75-79	11.2	5.0	16.2
80-84	17.9	8.2	26.1
85-89	7.2	2.2	9.4
90+	5.0	3.2	8.2
	67.7%	32.3%	100.0%

N=402

TABLE VII

Percent of Abused Elders by Living Arrangement and by Length of Residence with Caregiver

Living Arrangement	Percent	Length of residence with caregiver	Percent
Live alone	30.1%	4 or fewer years	26.3%
Reside with caregiver	69.9%	5 - 9 years	17.4%
		10+ years	56.2%

N=402

Abuser characteristics are presented in tables VIII and IX. As the data in Table VIII suggest, 24.4% of all abusers of elderly persons identified in this study are unrelated caregivers while 75.6% are family members of which 60% are males. As indicated, the son is the most frequent abuser followed closely by the daughter.

TABLE VIII

Percent of Abusing Caregivers Within Each Category of Relationship to Victim

Relationship	Percent
Son*	23.6%
Daughter*	21.2
Husband	16.4
Wife	4.5
Brother	3.7
Sister	2.2
Niece	1.7
Nephew	1.2
Grandchildren	1.0
Unrelated Caregiver	24.4

N=402

* Includes in-laws

Of all abusive caregivers identified in this study, 36.3% were found to be over 60 years of age. Table IX presents the age distribution of caregivers over the age of 60.

TABLE IX

Percent of Caregivers by Age Cohort 60 Years of Age and Over

Age	Percent
60-69	48.0%
70-79	31.5
80+	20.5
	100.0%

N=146 (36.3%)

According to Lau and Kosberg (1979), as more people now live longer it is becoming more common to find caregivers who are themselves elderly. The caregiving responsibility often creates stressful situations for persons ill-equipped by reason of age to assume this responsibility. According to Lau and Kosberg (1979), persons experiencing this stress are potential abusers. In research conducted by Steinmetz (1981) 39% of caregivers were over 50 years of age and 18% were over 60. Thus, 57% of caregivers were elderly or approaching this stage, and in addition to retirement or imminent retirement, fixed incomes, and increased health problems, were assuming the responsibility for the care and protection of an older dependent family member. According to Steinmetz, the effects of this additional burden upon elderly caregivers who may be emotionally or financially unprepared or unable to assume the responsibility may be stress, resentment, and frustration, with the result that the elderly individual requiring care becomes vulnerable to neglect or abuse.

Respondents were asked to state the methods through which cases of elder abuse were identified -- had they received referrals or reports of abusive situations from friends, neighbours, or relatives of the abused elderly persons, from other agencies or other professionals, or had the situations become identified through routine home or office visits. The data indicate that Eastman respondents identified one-half of all abusive situations through referrals from other agencies or professionals, and one-half through respondents' routine home visits. Respondents in Winnipeg Region reported that 17.4% of all abuse cases encountered had been identified through hospital admissions while 37% were identified through respondents' routine home visits. In all other regions routine home visits accounted for the greatest percentage of all methods of identification of abusive situations (ranging from 60% for Central Region to 100% for Norman Region). The overall provincial percentages are presented in Table X. The remaining 29.5% of methods of identification included referrals from friends, neighbours, relatives, anonymous individuals, self-referrals, and for example, reports from businesses such as utility companies.

TABLE X

Percent of Respondents' Methods of Identification

Methods	Percent
Routine visits	60.0%
Reports/referrals from other professionals or agencies	2.9
Hospital admissions	7.6
All others	29.5

N=105

As indicated in Table XI, the data suggest that for all regions within the province 1.3% of all clients/patients age 60 or over served by respondents within the past twelve month period are identified as abused persons.

TABLE XI

Percentage of respondents' clients over 60 years of age identified as abused within twelve month period by region

Region	Percent
Norman	7.5%
Eastman	6.7
Interlake	5.6
Parklands	4.4
Central	3.0
Westman	2.6
Winnipeg	.7
Provincial Total	1.3

TABLE XII

Percent of respondents' perceptions of abuse, by abuse category by whether abuse was intentional or unintentional

Category / Intent	Financial	Physical	Psychosocial
Intentional	42.9%	28.6%	25.7%
Unintentional	46.7	60.9	63.8
Undecided	10.5	10.5	10.5

N=105

As reported in Table XII, most respondents perceived more of all three categories of abuse to be unintentionally caused. Respondents perceived such unintentional abuse most often to be the result of care-givers becoming overwhelmed by the responsibility of caring for an elderly individual, due to a lack of time, energy, or resources either financial or emotional. Factors also identified as contributing to the lack of provision of adequate care and to unintentional abuse were a lack of care-giver perception or sound judgement in decision-making with an unawareness of the effects or consequences for the elderly person.

Respondents were asked if abuse cases were documented on the client/patient file, if any official or legal action had been taken, and whether or not there were set directives for the handling of elder abuse cases. The vast majority of respondents (92.4%) stated that instances of elder abuse were documented on the elderly persons' files. 77.1% of respondents had taken no official or legal action in abuse cases. The types of official/legal action taken by the remaining 22.9% of respondents included such actions as returning financial control to elderly persons, closing guest homes, court action in which elderly persons' funds were recovered, medical arrests in order to secure medical examinations of elderly persons, court action regarding homicide and assault of elderly persons, and initiating Orders of Supervision to transfer control of elderly persons' finances to the Public Trustee.

99% of respondents had no set directives for handling or resolving encountered cases of abuse. These respondents followed informal procedures which are presented in Table XIII.

TABLE XIII

Percent of Respondents who Followed Informal Procedures

Informal Procedure	Percent
Refer to other agency or professional	41.0%
Counsel caregiver	41.0
Staff discussion	33.3
Counsel abused client/patient	21.0
Initiate home care services programs	13.3
Placement in personal care home	9.5
Remove to alternate shelter	5.7
Initiate Order of Supervision	3.8

N=105
Does not total to 100% due to use of multiple procedures.

Respondents were asked to identify factors which, in their opinion and experience, were indicators of situations with a high risk of potential abuse for elderly persons. Tables XIV and XV present these high risk indicators concerning elderly persons and caregivers respectively.

TABLE XIV

Percent of Respondents Identifying High Risk Factors Concerning Elderly Persons

Factor	Percent
Physical Impairment	24.8%
Suspicious physical injuries	24.8
Mental status (eg. confused, unstable)	22.9
Depression, withdrawal, anger	18.1
Lack of family supports	13.3
Poor family relationship	13.3
Overcrowding	10.5
Social isolation	7.6
Wealth or many assets	7.6
Residing with family member	7.6
Extremely demanding and difficult	6.7
Geographic isolation	4.8
Living alone	4.8
Other	11.4

N=105

TABLE XV

Percent of Respondents Identifying High Risk Factors Concerning Caregivers

Factor	Percent
Alcoholism	44.8%
Financial Stress	15.2
Poor attitude toward aging	10.5
Poor coping ability and emotional resources	8.6
Age 60 and over	5.7
Mentally unstable	5.7

N=105

As indicated in Table XIV, respondents most frequently identified physical impairment of an elderly person and suspicious physical injuries as factors which indicate possible situations of high risk of abuse. These were followed by the elderly person's mental status, depression, withdrawal, or anger, lack of family supports, a poor family relationship, and over-crowding. Also identified as indicators of high risk were situations involving social isolation, wealth or considerable assets, and an elderly person residing with a family member. Less frequently mentioned as indicators of high risk situations were descriptions of elderly persons as demanding and difficult, followed by geographic isolation and living alone. The 11.4% of high risk indicators represented in the "other" category in Table XIV include such factors as an unexplainable lack of funds, a lack of knowledge of available services and modes of access, a rapid health status change, frequent hospital admissions, residing in unliscenced guest homes, a caregiver over-eager for institutional placement, and when all responsibility for care of an elderly person is placed on one person.

As indicated in Table XV, alcoholism was the most frequently identified high risk factor concerning caregivers. This was followed by caregiver financial stress, poor attitude toward aging, poor coping ability and emotional resources, caregivers aged 60 years and over, and mental instability.

Interestingly, many of the factors identified here as indicators of situations of high risk are similar to those identified by the Seven Oaks General Hospital (Appendix B, Page56).

Respondents' opinions regarding the issues of mandatory reporting of elder abuse cases to a central registry, the formation of a protocol and legislation specifically concerning elder abuse, and the formation of advisory committees are presented in Table XVI.

TABLE XVI

Percent of Opinions Regarding Mandatory Reporting, Protocol, Legislation, and Advisory Committee

Favourability Towards:	Yes	Under certain conditions only	No	Undecided
Mandatory reporting	81.0%	7.6%	6.7%	4.8%
Protocol	87.6	1.9	5.7	4.8
Legislation	84.8	1.9	8.6	4.8
Advisory committee	88.6	3.8	6.7	1.0

N=105

As indicated in Table XVI, the majority of respondents were in favour of mandatory reporting to a central registry, the formation of a protocol, legislation, and advisory committees. The 7.6% of responses indicating favourability towards mandatory reporting of abuse cases under certain conditions only, included conditions in which the reported information would contain no names and be used strictly for research purposes, and the condition that mandatory reporting apply only to life-threatening or unresolvable situations. Also included under favourability towards mandatory reporting under certain conditions only, were stipulations that financial and psychosocial abuse not be included. The rationale being that these areas are best resolved through counselling rather than law, and that psychosocial abuse in particular is too subtle and determinations too subjective to be identifiable with any degree of certainty.

1.9% of respondents were in favour of protocol and legislation under conditions of these applying only to physical and financial abuse. The rationale again being that forms of psychosocial abuse are best resolved through counselling alone.

Respondents not in favour of mandatory reporting, protocol, legislation, and advisory committees under any circumstances generally stated that these

would involve too much bureaucracy and thus hinder the delivery of services. Unfavourability towards advisory committees was generally due to similar feelings -- that such endeavours would involve increased bureaucratic procedures and would ultimately be a hindrance to action. However, 3.8% of respondents were in favour of advisory committees under the condition that current, established committees be utilized, (such as a gerontological group), rather than the formation of new entities.

Of the 88.6% of respondents favouring advisory committees, Table XVII presents opinions concerning necessary membership.

TABLE XVII

Percent of Respondents who Identified Advisory Committee Membership

Favoured member	Percent
Social worker	77.1%
Nurse	67.6
Doctor	63.8
Lawyer	40.0
Psychiatrist	28.6
Gerontologist	21.0
Elderly lay person	20.0
Police officer	19.0
Mental health	16.2
Other individuals and professionals	16.2
Other social service agencies	14.3
Clergy	12.4
Concerned citizen	10.5
Continuing care coordinator	8.6
Income security	6.7
Alcoholism Foundation of Manitoba member	4.8

Does not total 100% as more respondents favoured 3 or more members.

Discussion of Findings:

On the basis of the findings reported in this study, it appears that abused elderly persons are likely to consist of a greater number of women aged 80-84 years, residing with a family member for 10 or more years. In accord with previous studies (Lau & Kosberg 1979; Hickey & Douglass 1981b; Steinmetz 1978, 1981), family members were found to be the most frequent abusers of elderly persons. Unlike the findings of Lau and Kosberg (1979) who found the daughter to be the most likely abuser, followed by the son and then the spouse, or findings of Hickey and Douglass (1981b) that the most frequent abuser is the spouse, the son, and then the daughter, this study finds the son of the victim to be the most likely abuser, followed by the daughter, and then the spouse.

The type of abuse most frequently encountered was financial, followed by psychosocial and physical. The most common form of financial abuse involved caregivers cashing the elderly persons' pension/social insurance cheques and withholding the funds. It is not difficult for family members to obtain control over the elderly persons' financial resources. Legal mechanisms such as Power of Attorney and Committeeship were not always involved, and financial control by relatives was often an informal arrangement. It was found that many elderly persons who voluntarily or unvoluntarily had their finances controlled by relatives, had the funds withheld and misused.

Verbal/emotional abuse was the most frequent type of psychosocial abuse, followed by inadequate attention, isolation, and confinement. It was not uncommon for elderly persons to be confined to small, dark, cold cellars, basements, and bedrooms.

Physical assault was the most frequently encountered type of physical abuse, followed by the withholding of food. In these cases the elderly persons were frequently described as severely malnourished and dehydrated. Physical abuse ranged from severe beatings causing bruises, welts, and fractures to actual homicide.

A large number of abusive caregivers were found to be over 60 years of age. This is in accord with previous research findings (Anderson 1981; Lau & Kosberg 1979; Steinmetz 1981) suggesting that many caregivers are themselves likely to be elderly. This suggests that the responsibility of caring for a dependent elderly person, together with the caregiver's own status -- retirement, fixed income, increased health problems -- combine to produce a breaking point and a situation conducive to abuse.

Outside observation tended to be the primary means of identifying abuse cases. 60% of the cases were identified through routine visits by respondents. Only a small number of cases were identified through referrals from family members, victims, or other individuals. A substantial number of cases were identified through hospital admissions. According to Rathbone-McCuen (1980: 302), many hospital emergency room staff have developed a sophistication in diagnosing child abuse and pediatric social workers may be on hand almost immediately. However, comparable expertise currently is not available to the elderly. Until these, and other professionals, are trained to recognize elder abuse, we may expect the number of identified cases to represent only the "tip of the iceberg".

Of the 120,000 persons in Manitoba over 65 years of age, approximately 15% (18,000) receive care of some kind from informal care providers or home service agencies. The 402 cases of elder abuse reported in this exploratory study suggests that 2.2% of these 18,000 persons receiving care are experiencing abuse of some kind at the hands of caregivers. Further, the 402 cases of elder abuse reported here suggest that of Manitoba's total aging population, approximately 120,000 persons over the age of 65, .3% are experiencing abuse. We might expect that, as with other forms of abuse reports, for example, child abuse, the cases reported represent only the "tip of the iceberg" (Thorman, 1980). This suggests, then, that the figure is in reality much higher than 2.2%.

It is clear that we are faced with a problem of considerable dimension and seriousness. This research endeavour has sought to explore the extent and nature of the problem and has been useful in several respects. It reports

on various aspects of the issue in that the variety of professions encountering elder abuse were identified, types of abuse were described and responses to incidents reported, and several characteristics of abused elderly persons and abusing caregivers were identified. Most importantly, this study confirms the existence of elder abuse within the province and establishes a preliminary estimate of the incidence and types of abuse most frequently experienced by the older population.

The findings reported here, while representing only a first step toward exploring the extent and nature of elder abuse, raise some interesting questions and suggest further areas for future research and issues for program development. The development of interview items designed to tap further areas of the problem, areas not explored in the present study, might include questions concerning the relationship between elder abuse and disability related dependency. More detailed and elaborate research in the area of elder abuse would be helpful for developing criteria for case identification, direction for planning intervention and prevention strategies, and providing a foundation for change in social policy or legislation. Thus, a major objective of future research should be the identification of effective means for isolating elder abuse cases. Hence, primary contributing factors or conditions in situations of abuse must be described with sufficient confidence to give professionals some guidelines in identifying potential cases. So also, the end product should be the identification of effective means for treating elder abuse and alleviating those conditions which appear to promote it.

Limitations:

While this study has several limitations, it offers a limited analysis of the extent and nature of elder abuse which it is hoped will contribute to a clearer understanding of the problem. However, more information and more empirical data concerning the incidence and prevalence of elder abuse are needed in order to provide a more comprehensive knowledge base.

There are several limitations to this study which must be specified. The 402 cases of elder abuse reported here do not necessarily represent 402 cases since some few respondents may have been reporting on the same case. Hence, although strict precautions were taken to guard against it, the possibility of duplication must be recognized.

This exploratory study does not represent a random sampling of any population. Therefore, findings are not capable of being generalized beyond this data set. Findings generated through this study should be verified through more sophisticated research techniques and a replication of this study employing random sampling techniques would allow for generalizations concerning the findings.

IMPLICATIONS AND RECOMMENDATIONS:

The serious nature of elder abuse creates a need for various professions to develop more effective methods for the prevention of abuse. Professionals must be alert for the signs and symptoms of elder abuse and be aware of situations that provoke potential abuse so that appropriate interventions can be used. However, at present, there appears to be a lack of professional awareness of the problem and a reluctance to identify it. These barriers were also present in the early stages of child abuse treatment and intervention and can be overcome through educational techniques and consciousness-raising devices.

Perhaps an effective educational device for increasing professional awareness may be training sessions and seminars that focus on the forms and dynamics of elder abuse, as well as risk indicators, and possible treatment strategies. Although Westman Region has the highest proportion of Manitoba's elderly rural population, professionals in this region identified proportionately fewer cases of elder abuse than any other region in the province. Perhaps, then, training sessions and seminars designed to increase awareness of the problem could begin with Westman. Alternatively, insight into effective preventive strategies may be gained through investigation of techniques employed in Westman, if indeed the proportion of abused elderly persons to the area's aging population is accurate.

As previously discussed under "Risk Reduction Strategies", general public awareness to the problem of elder abuse must be heightened and educational techniques developed to educate caregivers in caring for elderly persons. Counselling should also be made available to families faced with caring for an elderly person. Information concerning community resources should be widely disseminated in order to increase knowledge of existing services and modes of access. This information might concern, for example, eligibility for, and methods of acquiring, financial aid as well as information regarding the availability of community home care services, day care centres, and any other special programs available to elderly persons and their families.

The development of effective identification techniques will undoubtedly increase the need for more day care facilities, in-home services programs, temporary shelters, and respite care facilities.

Laws for protection of elderly persons are clearly needed. This need includes a law which would provide for mandatory reporting of elder abuse, neglect and exploitation, and immunity for persons reporting instances of abuse. It may be desirable to extend some of the management techniques currently being developed or utilized in the field of child abuse to the area of elder abuse. For example, a central registry could be established through reporting to a specialized agency committeed to the probelm -- a social service protective agency -- rather than directly to law enforcement officials since the latter connotes a criminal or punitive response rather than a civil or therapeutic one. A social service protective agency should be a body geared to stimulate the necessary preventive and supportive steps upon receipt of a report. These reports might include descriptive information concerning the type of abuse and suspected abuser, along with the victim's name, age, sex, and place of residence. The types of information contained in Tables XIV and XV (page 54) concerning high risk factors should prove to be very useful to the identification process and subsequent reporting. The registry reports might also include descriptions of any corrective measures undertaken in the cases.

There are elderly persons who would clearly benefit by being removed to a place of safety. But the question is -- to where? Unless a registry would be a stimulus to positive action, there would be little point in setting up the machinery. Thus, in addition to cooperation from various professions and agencies, institutional and other facilities to deal with the problem must be ensured.

The legal requirement to report does not eliminate uncertainty regarding the relationship between those cases reported and the true incidence of abuse. However, perhaps the most effective method of discovering something like the true incidence of elder abuse lies in systematic reporting and registration of suspected cases.

Finally, there apppears to be a need for consultation teams to aid in determinations of the need for intervention and subsequent corrective strategies in cases of elder abuse. These advisory committees, composed of representatives from various occupational groups, would also periodically review cases to determine the need for further risk-reduction strategies, revise plans in light of new information and new needs, and formulate not only preliminary but also long-term recommendations. There is a clear need for the multi-disciplinary team approach represented by such advisory committees in order to effect the successful identification and management of situations of abuse.

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APPENDIX A

INTERVIEW ITEMS

1. Approx. Number of cases involving elderly clients over the past year.

2. How many of these have involved protective problems.

3. How would respondent identify or define situations involving protective problems in the financial, physical, and psychosocial areas.

4. Descriptions of cases with breakdown into the three categories.

   (age, gender, location, approx. length of residence, relation and residence of caregiver, names)

5. In respondent's opinion was the mistreatment intentional or unintentional.

   (Unintentional abuse may involve a lack of time, energy, emotional or financial resources for provision of adequate support and protection. Or may be due to a lack of judgement or perception in decision-making with an unawareness of the effects.)

6. Are reports or referrals of abuse incidents received from friends, relatives, neighbours, agencies. Or are they self-reported or identified through office or home visits.)

7. What other professionals became involved in relation to the abuse case(s).

8. Are suspected cases documented.
   (If so, where -- client's file, separate place, memo without file copy?)

9. Any cases involving protective problems where action has been taken -- official or legal?

10. Any set directives for handling the cases? If not, what is the informal procedure or what would respondent do.

    (Any agency or individual respondent would alert? Is verification achieved through personal observation, home visits, or speaking directly to elderly person? Follow-up or case-monitoring procedures?)

11. What factors could be identified as indicators of situations of actual or potential abuse (high social risk indicators).

12. Who does the respondent feel are the experts or who has been helpful to them in dealing with cases of abuse?

13. Mandatory reporting to a central registry of incidents involving protective problems would provide information as to the extent of the problem, as well as to protect the person through appropriate intervention. Would respondent be in favour of mandatory reporting? Of all cases, only cases of physical abuse, only where there has been legal action, etc. If not, why?

14. Professionals have protocol (as to how to identify and proceed) for assisting in cases of child abuse. Would respondent like to see legislation and/or protocol for assisting in cases of mistreatment involving the elderly?

15. Would respondent be in favour of an advisory committee (or some other entity) with representatives of various professions for review and consultation of identified mistreatment cases. And who should comprise this committee. (If not agreeable to such a committee then what other group would respondent be in favour of?)

APPENDIX B

SEVEN OAKS GENERAL HOSPITAL

STUDY OF ELDERLY ABUSE

INFORMATION PACKAGE

Contents

1. Introduction

2. Guidelines

3. High Social Risk Factors

4. Reporting Sheet

5. Articles

- Abuse of the Elderly by Informal Care Providers
- Unveiling a Family Secret
- Elderly suffering widespread abuse

1981 06 15

SEVEN OAKS GENERAL HOSPITAL

STUDY OF ELDERLY ABUSE

INTRODUCTION

Definition: (For purposes of study at Seven Oaks General Hospital)

Physical abuse or physical neglect inflicted on elderly persons (60 years of age or over) by informal care provider(s), i. e. relative(s) or care providers in the community excluding those employed by institutions or community agencies.

Purpose:

1) To identify circumstances which may indicate abuse or neglect.
2) To alert staff and discharge planners to the need for measures or resources which can alleviate or reduce risk factors in the patients' living arrangement. This may protect elderly and frail patients who are returning to potentially unsafe home environments.

Method:

1) To inform and alert staff to the increasing incidents of abuse of the elderly in society.
2) To utilize guidelines for detection.
3) To document suspected cases at Seven Oaks General Hospital.
4) To report annually on March 31st of each year.

Inquiries regarding the study should be directed to the following Committee Members:

Dr. J. Hurwitz, Head, Dept. of Geriatrics	Local 3112
Marilyn Robinson, Director of Nursing (ex officio)	" 3366
Jeanette Block, Director of Social Services	" 3146
Myrna King, Nursing Unit Manager	" 3401
Anne Marie Bell, Nursing Unit Manager	" 3231
Janice Friesen, Nursing Unit Manager	" 3495
Leona Kaban, Nursing Unit Coordinator	" 3104
Carol Wroblewski, Nursing Unit Coordinator	" 3402

GUIDELINES
STUDY OF ELDERLY ABUSE

1. DEFINITION: (For purposes of study at Seven Oaks General Hospital)
Physical abuse or physical neglect inflicted on elderly persons (60 years of age or over) by informal care provider(s), i.e. relative(s) or care providers in the community excluding those employed by institutions or community agencies.

The abuse or neglect is sustained by non-accidental means.

The suspected abuse or neglect should be monitored and recorded so that if and when a pattern of behaviour (in this case, repeated admissions or visits to Emergency) is identified, the individuals involved may be directed to some means of intervention, preferably by a professional.

2. GUIDELINES: Any combination of the following circumstances may alert staff to potential abuse situations and should be recorded.

A. Possible Reactions and Attitudes of the Abused Elderly

1. Physical Appearance
   i) unexplained bruises, markings, etc.
   ii) unkempt-poor hygiene and lack of personal care.
   iii) undernourished and dehydrated when mental alertness enables expression of needs but immobility prevents independently meeting these needs.
   iv) shows injuries not consistent with those explained in the history.
2. Emotional Reaction
   i) denial of any problems with relations with care providers.
   ii) resignation, acceptance of abuse as part of life - no recourse.
   iii) emotional withdrawal-passivity.
   iv) fear-may ask what will happen next or physical withdrawal upon physical contact.
   v) settle very well into the medical setting.
   vi) overprotectiveness towards the care provider.
   vii) show no expectations of being comforted.

B. Possible Reactions and Attitudes of the Abusing Care Provider.

1. Does not readily volunteer information concerning injury or illness.
2. Shows irritation concerning any plans or does not get involved in planning.
3. May be evasive and contradictory regarding the circumstances.
4. Shows no concern regarding developments in treatment or progress, or else demands early discharge.
5. Does not visit, or if he/she visits, does not focus on the individual.
6. May be very critical of the abused person and never mention good qualities.
7. May show feelings of worthlessness in themselves and the abused person.
8. May exhibit violent feelings and behaviour and, in interviewing, may reveal that this was a pattern in their family.
9. Is under great personal stress and conflict.
10. May have a history of alcohol abuse, retardation or mental illness (psychotic or psychopathic).
11. May be physically disabled and unable to provide the care.
12. Has no support to aid in dealing with stress of providing care.
13. May doctor/hospital shop.
14. Has unrealistic expectations of the person and health care professionals.

C. Additional Indicators by Both Individual and Care Giver

1. Delay in seeking help.
2. History of repeated injury/illness.
3. Refuses consent for diagnostic tests.
4. Situation of environmental problems such as poor housing, overcrowding, financial crisis.

3. REPORTING

Suspected cases of abuse should be reported to Social Service Department by forwarding a consult form indicating the appropriate number from the High Social Risk list. Those numbers asterisked (*) may be particularly applicable.

1981 06 15

SEVEN OAKS GENERAL HOSPITAL

Department of Social Services
IDENTIFICATION OF HIGH SOCIAL RISK CASES

The following criteria will assist nurses in identifying patient characteristics and situations which indicate a high probability that social work services will be needed.

1. Admitted from any institution, personal care home, foster home, group home or "guest" home.
2. Known to Home Care or other health and social service programs (Mental Health, Mental Retardation, etc).
*3. Disabled or over 65 years, living alone or with infirm care provider.
4. No known family, close friends or social support system.
5. Non-resident of the City of Winnipeg.
6. Condition will negatively affect self-image, appearance and physical and/or sexual functioning.
*7. Observed or stated family relationships negatively affect care, treatment or compliance with medical recommendations.
8. Patients and families with catastrophic illness or accident, (massive C.V.A., amputations, etc).
9. Terminal stage of illness.
10. Condition will require a change in education, employment, income, housing, family roles.
11. Parents of newborns who are premature or with birth anomalies.
12. New mothers without partners or extended family support.
13. Teenage parent(s) or single parent with minor children.
14. New mothers with lifestyles which would interfere with obtaining medical care or providing adequate care for an infant, (drug or alcohol abusers, psychiatric problems, mental retardation).
15. Child relinquishment.

In these situations, referral to social work is indicated. If the nurse is uncertain as to whether a referral is appropriate, the referral should be made anyway. The consultation form may be used. The social worker will then discuss the situation with the nurse and make the decision.

The following high risk indicators will involve social services in conjunction with a psychiatric assessment where deemed appropriate.

*16. Suspected victims of abuse, (physical/sexual) neglect or violence, attempted or threatened suicide.
17. Suspected alcohol or drug dependency.
18. New parents with infants with drug or alcohol withdrawal.
19. Prolonged fear and/or anxiety about recommended procedures.
20. Behaviour (patient or family) is disruptive to treatment.

1981 06 15

SEVEN OAKS GENERAL HOSPITAL

Department of Social Services

REPORTING SHEET - - SUSPECTED ABUSE

Date	Name	Sex M/F	Address	Age	Hospital #	Referred By	Indicator(s)	Action Taken
								1981 06 15